

1974

An Exploratory Study to Assess Client Expectancy of Counseling Gain

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AN EXPLORATORY STUDY TO ASSESS
CLIENT EXPECTANCY OF COUNSELING GAIN

by

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A report submitted in partial fulfillment of the
requirements for the degree of

MASTER OF
SOCIAL WORK

Portland State University
1974

APPROVED:

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This exploratory study is designed to investigate the role of pre-counseling client expectancy as it affects the outcome of initial-interview counseling. To facilitate investigation into this area it was necessary to develop a measuring instrument whereby an individual's expectation of the success of counseling could be assessed. This instrument was then administered to beginning clients at two counseling facilities.

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ACKNOWLEDGMENTS

I wish to express my appreciation to the staffs at Multnomah County Family Services and the Portland State University Counseling Center for taking the time and effort to perform the actual research.

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INTRODUCTION

The question of the role of the various "non-specific" factors in psychotherapy has long been the subject of conjecture and study. One such element which has been suggested as an important component of psychological treatment is that of "expectancy of therapeutic gain." This rather vaguely defined explanatory construct has intuitive appeal and has prompted numerous research efforts aimed at the discovery of its contribution to the therapeutic process.

Expectancy (or instrumentality) theory has often been used as the basis of research attempting to relate attitudes and behavior. Some writers treat expectation as a "trait" which individuals bring to the counseling session and others treat it as a "state" to be experimentally induced by the researcher. As is quite often the case with attitude-behavior investigations there has been a lack of significant results.

A number of different aspects of the expectancy construct in relation to psychotherapy have been defined and investigated. The works of Apfelbaum (1958), Goldstein (1960), and Sloane et al. (1970) have served to define relevant dimensions and to highlight the importance and meaningfulness of the role expectancies of the participants in psychotherapy.

Data obtained by Chance (1959) indicate that therapist prognostic expectancies may be a factor of major proportion in therapy outcome. This study demonstrated that therapists with more optimistic expectations for success brought about more positive change in their patients

than did therapists with a less optimistic bias, given equal levels of patient psychopathology. The influence of therapist expectations has been thoroughly documented by Rosenthal (1966) and discussed by Pope et al. (1972) and by Wilkins (1971, 1973). Bednar (1970) goes as far as to suggest that the success of psychotherapy

... is not a result of the validity of specific counseling procedures; rather it is because of the actual irrelevance of the specific counseling methods employed.

He concludes that improvement happens

... as long as each counseling system successfully imparts to the client the expectation that he should be improving as a result of the expert treatment he is receiving. (pp. 651-652)

Klein et al. (1969) commented upon how much the client's expectations are influenced by the direct and intended actions of even behavior therapists.

Here the therapist tells the patient at length about the power of the treatment method, pointing out that it has been successful with comparable patients and all but promising similar results for him too.

Indeed it seemed to us that treatment plans and goals were laid out in such a detail that the patient was taught precisely how things would proceed and what responses and changes were expected of him all along the way. (p. 262)

In a major investigation, Lennard and Bernstein (1960) found evidence strongly suggestive of the importance of the congruity or mutuality of therapist-patient expectations concerning in-therapy roles and communications. They concluded that

... when there is any degree of discrepancy or lack of consensus between the participants, and their expectations are dissimilar ... manifestations of strain appear in their interpersonal relations. If

the expectations are too dissimilar, the ...
system disintegrates unless the differences
can be reconciled. (p. 153)

A study by Lipkin (1954) supports the notion that a patient who is "positively oriented" toward therapy and who expects success will make more gains than a patient who has reservations. It is this last mentioned aspect of expectation, the patient's (client's) expectation of success of treatment, with which this paper is concerned.

Rosenthal and Frank (1956) argue that patients entering psychological treatment have varying levels of expectation concerning the success of treatment, and that these expectations may have much to do with the outcome of treatment. Although there is much theoretical and intuitive support for such an idea (Kelley 1949, Cartwright and Cartwright 1958, Goldstein 1962), research evidence to date has not been unequivocal. (Goldstein, for example, has even shown this to be the case when little or no therapy occurs. He followed a group of patients who had been seen only for intake interview, placed on a waiting list, and who never had therapy at all. He discovered that a large proportion of them had symptomatic improvement proportionate to their expectation of help from their intended treatment at the time of their initial contact). In surveying numerous studies which have investigated the phenomenon (Brady et al. 1960, Heine and Trosman 1960, Frank 1968), one finds that, in general, the authors express confidence in the validity of the relationship, yet no firm evidence for the positive relation of patient expectation and outcome has been found.

Following investigation concerned with the above problem this writer is in agreement with Wilkins (1973) when he says

It appears from the literature reviewed that the construct "expectancy of therapeutic gain" emerged prematurely and without the empirical support necessary to establish its validity. (p. 75)

Inspection of a representative research effort in this area sheds some light on a likely factor contributing to the dearth of positive results. For example, in a study by Brady et al. (1960) a high expectation and low expectation group were compared in terms of treatment success. At termination, the groups were not found to differ in therapist ratings of improvement. Such a finding argued for rejection of the hypothesized relation between patient expectation of success and actual outcome.

This study can be criticized with regard to the assessment of expectation. Brady used two projective measures of attitudes toward psychiatric hospitals (the Picture Attitudes Test and the Sentence Completion Attitude Test developed by Reznikoff et al., 1959) in order to assign subjects (hospitalized patients) to a high or low expectancy group. It is of considerable question whether attitudes toward hospitals (or other treatment centers) in general can appropriately be used as accurate estimators of specific expectancy of success. Empirical data bearing upon this objection were provided by Wicker (1969). In this study, students' attitudes toward scientific research in general were found to be unrelated to the extent of their participation as subjects in a psychology experiment, while more specific attitudes toward participating as a subject in psychological research had a significant positive relationship with extent of actual participation.

Examination of the relevant literature reveals that other studies

in the area of expectation of treatment success have shared similar weaknesses in the area of assessment. Typically, one of four approaches has been employed in dealing with this problem. One was that used by Brady et al. (1960), whereby an attitude scale was assumed to be an estimator of expectancy level. The major objection to this approach has been noted above.

Another method of dealing with the concept of expectation of success involves an attempt at the experimental manipulation of its level (Frank et al. 1959). Theoretically this approach is quite sound; the problem would appear to be a practical one. Usually the effectiveness of the manipulation (e.g., a therapist telling the client the treatment is good or bad) is simply assumed and no attempts are made to determine if, and to what extent, the manipulation works. Also, such an approach does not allow for individual differences in reaction to the treatment. It has been demonstrated that some subjects respond well to an attempt at expectancy manipulation while others do not (Gliesman et al. 1958).

A third approach to the assessment of expectancy is just to ask the client if he expects to get well. Although this method has the virtue of directness, it is doubtful whether it can actually be of use to the researcher. Such a factor as willingness to adopt the "sick" role could easily confound the level of expectation obtained by the use of direct questioning.

A fourth approach, a modification of the direct method, whereby the client makes a number of statements concerning symptom distress, has been employed in a number of studies (Goldstein and Shipman 1961, Piper

and Wogan 1970). The investigation of Goldstein and Shipman was illustrative of this method. Prior to treatment patients were given a symptom checklist to complete. This checklist was concerned with the patients perception of self as related to two time dimensions; these being his current perception of self ("present self") and the person he expected to be following treatment ("expected self"). Difference scores between present and expected ratings of symptoms constituted the operational definition of expectancy level for each subject.

This experimental method, of the four, contains the lesser magnitude in terms of objections and appears to yield the most acceptable measure of expectancy. Next, this method can readily be expanded to include both client and counselor post-treatment measurement. Thirdly, avoided are the difficulties inherent in attempting to assess the individual's attitudes through projective-type measures. Further, and perhaps just as important, there is no attempt made to manipulate the client through trying to artificially bring about an experimentally induced expectancy "state" for research purposes.

For these reasons this conceptual approach is employed in the present study. However, in examining this method for suitability, a number of problems soon become evident. These revolve about:

The Rating Process. The way in which a person perceives his problems may be affected by the process of going through the questionnaire.

Timing. A person experiencing significant psychological distortion at the time of completing the questionnaire may well lack the perspective necessary for accurately responding to the items.

Consistency. The client's efforts to appear consistent to the counselor may lead to reporting a fulfillment of expectancy (e.g., symptom reduction) similar to the one he states he expected.

Initial Expectancy. Persons with high discomfort (symptom intensity) will be able to report marked improvement while those with low initial discomfort can only have low expectancy and therefore low actual therapeutic gain. Bearing this in mind it then becomes possible that any difference in gain between the two groups with high and low expectations will be exaggerated by the difference in the initial scores of their members, unless relative or corrected measures are used.

The Problem

A search of the literature has revealed that, although many scales for the assessment of various different aspects of expectancy exist, there is no generally accepted measure of the expectation of success. It is clear that there is great need for an economical, objective, reliable, and valid instrument to assess an individual's expectation of the success of counseling. The lack of such a tool must inevitably slow progress in this area of research and, to the extent that expectancy plays an important role in counseling, the lack of such a basic measure clouds important aspects of the general area of measurement of counseling effectiveness (e.g., counseling outcome as related to expectancy).

The scope of the present study does not permit the large-scale sampling and data collection necessary to validate such an instrument. It is believed, however, that further research effort in this area is justified due to the equivocal nature of the conclusions reached thus

far regarding expectancy. The current investigation is, therefore, concerned with the development of an economical measure of an individual counselee's expectation of the success of counseling for his presenting problems. It is the author's opinion that development of a meaningful index, with appropriate measures, regarding client expectancy will yield a useful tool for counselors-in-training as well as for further use in research.

RESEARCH DESIGN AND METHODOLOGY

The Expectancy Measure

The first step in the development of the instrument involved the generation of an item pool. This was accomplished intuitively, whereby questions appearing relevant to the construct to be assessed were formulated by the author. Many of the ideas for the items are found in the literature of those doing research in the same or related areas. After discussion with several psychologists, counselors, and social workers, 26 items which were clear, unambiguous, and contained only one idea per item were selected for inclusion in the initial pool. The items each consisted of an single statement or question followed by four alternative responses or ways of completing the statement. The alternatives were designed (with the exception of the non-expectancy, informational questions) so that each seemed to represent a different level of expectation. For each item the alternatives were ranked in order from high to low expectancy. For scoring purposes the alternatives for each item were assigned an integer value (1, 2, 3, or 4) in accordance with their ranking; a weighting of one indicating the alternative ranked lowest, on up to four indicating the alternative ranked highest. Total expectancy score was defined as the sum of the values of the alternative chosen for each item.

Following pretesting the questionnaire was reduced to 22 items. In final form the ranked alternatives were presented in either ascending or descending order of expectancy. For example, the item which asked

for an estimate of the need for future counseling, the response order is: definitely will, probably will, probably will not, definitely will not. In this way the physical arrangement of the alternatives could be used as an aid in determining the most appropriate responses. The pretested version of the questionnaire is presented in Appendix A.

Included with the items was a question (item 1) on which the respondent was asked to indicate the nature of the problem which brought him to the counseling facility. Only subjects who indicated (both on item 1 and to their counselor) that they were seeking help with problems of a psychological (personal or emotional) nature were considered to be in the population of concern.

Setting

Two Portland counseling facilities were involved in the administration of the instrument between December 10, 1973 and February 15, 1974.

Multnomah County Family Services, an adjunct to the Court of Domestic Relations, provides non-fee counseling for a variety of problems relating to marital and family matters. Clients served live in the metropolitan area and constitute a fairly representative cross-section of local nationalities and races extending from welfare recipients through the financially-advantaged middle class. Three counselors holding the degree of Master of Social Work participated; their average number of years experience being 20.

The Portland State University Counseling Center provides non-fee student counseling for educational, vocational, and psychological problems. Although University students tend to represent many

nationalities and races, those utilizing Counseling Center services tend to be white and middle class. Of the 15 Counseling Center questionnaires included in the final data compilation, 13 were administered by five graduate student counselors-in-training and two by clinical psychologists. The student-counselors each had a minimum of one year supervised experience and were drawn from programs in psychiatry, psychology, social work, and urban studies.

Sample

At each facility subjects were randomly selected after two criteria had been met; the first being that they must be seeking counseling for personal or emotional problems (e.g., marital dysfunction, depression) of a psychological nature and the second being that they must not have received previous counseling at the facility.

Administration of Instrument

Three questionnaires were administered for each subject. Each client completed a pre-interview form in the reception room just minutes prior to their initial counseling session. At the interview's conclusion, while still in the counselor's office, both client and counselor simultaneously completed post-interview forms (the only item differing on the pre- and post-forms is item 22—see Appendix B). The counselors written and verbal instructions indicated he was to respond "as through the client's eyes; in other words, how you believe your client is responding to the post-interview form."

Clients placed both pre- and post-interview forms in sealed envelopes and neither client nor counselor saw each other's ratings.

Scoring

The items were then scored and the total expectancy scale score designated as the sum of the 12 items asterisked in Appendix A. Subsequent to instrument administration and evaluation, these 12 items were selected as representing the most direct, clear, and unambiguous questions or statements and alternative responses regarding expected therapeutic gain and, when considered in cluster, provide the best single measure of total expectancy. The total score for an individual could range between 12 and 48, with one point intervals (and half point intervals in the very few cases where a respondent chose two adjacent alternatives for the same item).

RESULTS

Table 1 and Table 2 indicate the expectancy scale results for the two counseling facilities. Two trends are apparent. First, that the client's expectation regarding the outcome of counseling is higher at the conclusion of the initial counseling interview than just prior to it; 22 of the 30 clients showing some degree of increased expectancy with five showing no overall change and three showing slight decreases. Second, the most significant finding of the study is that the counselors consistently rate the client's post-interview expectancy as being much lower than the client's self-rating. The mean post-expectancy score for the client's self-rating is 39.75 and for the counselors this score is 30.62. Of the 30 counselor-rated scales, 27 estimate the client's post-expectancy as being lower than the client's perception while one rating is the same and two show a one point higher estimate.¹

For analytic purposes the columns of Tables 1 and 2 are numbered consecutively and several column comparisons both within and between tables are made using t-tests and F-tests (see Table 3). (NOTE: several correlations were also obtained using the Pearsonian product-moment coefficient of correlation. These correlations range from .10 to .61, but are not included in this section as an r was used with the untested assumption that these data are interval data whereas they actually appear to be interval data. The results were inconclusive as was expected). Columns compared are:

Columns 1 and 6 to determine if there is any significant difference between clients of the two facilities on original (entering) expectations regarding the counseling process. The null hypothesis states that the mean (t-test) or variance (F-test) for the columns compared is the same and the alternative hypothesis is that Column 1 is greater than Column 6.

Columns 3 and 8 to determine if there is any difference in first counseling interview outcome regarding client expectation between the two facilities. The hypotheses are stated in the same order as above.

Columns 3 and 5 to determine if the Multnomah County Family Services counselors' rating of the client is affected by the amount of client progress (or lack of) during the interview. The hypotheses are stated as above.

Columns 8 and 10 are identical to Columns 3 and 5 except for facility.

Columns 5 and 10 to determine if there is any difference between the facilities regarding counselor-ratings. The hypotheses are stated in the same order as above.

TABLE 1

EXPECTANCY SCALE SUMMARY^{*}
MULTNOMAH COUNTY FAMILY SERVICES

Client	Client Pre-Score (1)	Client Post-Score (2)	Client Pre/Post Difference (3)	Counselor Post-Score (4)	Client Post/ Counselor Post Difference (5)
1	42	46	4	37	-9
2	40	44	4	33	-11
3	43	43	0	33	-10
4	34	44	10	29	-15
5	39	42	3	33	-9
6	28	38	10	30	-8
7	46.5	46	-.5	29.5	-16.5
8	26	29.5	3.5	24	-5.5
9	36	38	2	39	1
10	31	31	0	31	0
11	43	43	0	33	-10
12	39	41	2	24	-17
13	43	44	1	30	-14
14	33	36	3	29	-7
15	38	44	6	29	-15

^{*}Consisting of the 12 items asterisked in Appendix A.

TABLE 2

EXPECTANCY SCALE SUMMARY*
 PORTLAND STATE UNIVERSITY COUNSELING CENTER

Client	Client Pre-Score (6)	Client Post-Score (7)	Client Pre/Post Difference (8)	Counselor Post-Score (9)	Client Post/ Counselor Post Difference (10)
16	41	41	0	27	-14
17	39	35	-4	28	-7
18	37	38	1	39	1
19	31	34	3	23	-11
20	34	36	2	30	-6
21	40	45	5	32	-13
22	36	40	4	33	-7
23	35	41	6	34	-7
24	41	43	2	33	-10
25	40	40	0	30	-10
26	35	36	1	32	-4
27	37	38	1	30	-8
28	41	40	-1	29	-11
29	33	34	1	24	-10
30	35	42	7	31	-11

* Consisting of the 12 items asterisked in Appendix A.

TABLE 3

RESULTS OF T TESTS AND F TESTS
FROM THE DATA OF TABLE 1 AND TABLE 2

Column Source	t-test		F-test		
	P	Ho(.05)*	P	Ho(.05)*	Ho(.01)*
1/6	$\triangleright .05$	DNR**	$\triangleleft .05$	R***	
			$\triangleright .01$		DNR
3/8	$\triangleright .05$	DNR	$\triangleright .05$	DNR	
3/5	$\triangleleft .05$	R	$\triangleleft .05$	R	
			$\triangleright .01$		DNR
8/10	$\triangleleft .05$	R	$\triangleright .05$	DNR	
5/10	$\triangleright .05$	DNR	$\triangleright .05$	DNR	

* The null hypothesis states that the mean (t-test) or variance (F-test) for the columns compared is the same and the alternative hypothesis is that the first listed comparison column under "Column Source" is greater than the second.

** Do Not Reject

*** Reject

Table 3 Conclusions

t Tests

Significant differences were not found at the .05 level between clients of the two facilities on client pre-scores.

Similarly, no differences were found between facilities' clients on the pre- and post-score differences.

Also, no differences were found between facilities with respect to client versus counselor post-ratings.

There was a significant difference in each facility with respect to the client pre/post difference and the client/counselor differences in the post-ratings. This would have to be due to the counselors' under-estimation of clients' expectations.

The interesting findings of these analyses is that both clients and counselors in the two facilities performed similarly on the average.

F Tests

The variance of Family Service clients was greater than that of the Portland State University Counseling Center at the .05 level, but not the .01 level on pre-scores.

The variances on client pre/post and counselor/client post-scores was not significant at the .05 level in the Counseling Center.

Further studies would have to be made to determine whether these are real differences, chance, or due to differences in the statistical tests. The significance reappears when both facilities are combined.

On the remaining tests results bore out the t-tests. A series of studies with a large population is required to settle the questions

raised by the analysis so far—whether gains were real or spurious, whether counselors' ratings were real or affected by extrinsic considerations. It is fruitless to speculate at this point.

DISCUSSION

The concept of expectation of treatment success for problems of a psychological nature does not readily lend itself to specific description or analysis. Guilford (1965) incisively comments

The point is that success in any sphere of life is ordinarily highly complex and is determined by many psychological factors (rather than one or a few) ... We should, of course, attempt to single out the most significant aspects ... Too often some inconsequential aspects are chosen because of their ready observability and measurability. (p. 473)

The items selected to measure this construct for the initial scale represent the author's conception of the construct, and to the extent that counselors and researchers agree as to their reasonableness, they have a degree of face validity.

The format of the questions is one which has been used successfully in other attitude research as it allows for inter-subject response variance and reasonable degrees of reliability. The items were designed with sufficiently general content to allow use of the scale in settings other than those of the present study. The length of the instrument was kept short, taking approximately three minutes to complete, as it may be anticipated that individuals coming for counseling regarding personal or emotional problems often will be nervous, depressed, frightened, and in general not in a mood to respond accurately to a long series of items.

The exclusion of those who did not admit to personal or emotional difficulties seemed a conceptual necessity. It would be difficult to explain the meaning of a score indicating expectation of "getting better"

for a person who didn't view himself as somehow functioning "not well" from an intrapsychic standpoint.

Statistical Considerations

The conclusion that the final scale reliably measures a single construct cannot be inferred. Two tentative estimates of internal consistency were made.²

First, the difference of post-item 4 minus post-item 2 was obtained ($N=30$, $df=29$) and compared to the set consisting of columns 3 and 8. Item 4 pertains to the clients' expected "future state" and item 2 their "present state." It was believed that deriving a numerical value for the spread between "now" and "later" would approximate a measure of expected therapeutic gain. Columns 3 and 8 represent the clients' post-expectancy scale score minus the pre-scale score; or, what can be interpreted as therapeutic gain over the initial interview.

It was thought that comparing aggregate post scores for the two items pertaining to "now" and "later" with the pre(now)/post(later)-scale difference scores would yield a strong relationship. This presumed relationship was examined using both the paired difference t-test and the Pearsonian correlation coefficient. The results of each show intuitive logic to be at variance with statistical analysis. Using the paired difference t-test we are able to conclude at the .05 level that there is a statistically significant difference between the two comparison sets. The product-moment correlation derives an r of .10. These results lead to the conclusion that either these two dimensions examined are not the same or that we are measuring different variables or different aspects

of the same variable.

Another probe into internal consistency was to compare post-scale item 4 ("How well do you expect to feel about your problem(s) a month from now as a result of the counseling you receive here?") to post-scale item 12 ("I think my chances of doing better about my problem(s) because of this counseling are. . .") as they appear to be asking substantially the same question and the alternative responses are comparable. The item 4 and item 12 relationship tested with the product-moment correlation results in an r of .26, which gives a z score of .2661. As mentioned in RESULTS, here we are using the untested assumption that the data are interval data.

A partial explanation for this weak correlation perhaps hinges on the client's perception of the problem. For example, the individual might not believe his primary difficulty will be solved to any extent, but that the secondary problem of emotional distress will (e.g., he will learn to better accommodate to the situation). Cartwright and Cartwright (1958) considered another facet of this inconsistency regarding the client's belief that certain effects will result from psychotherapy. They observe that some researchers

... seem assured that the relation between degree of improvement and degree of belief will in general be strong and positive. But we have no confidence in predicting any particular relationship between degree of belief, that certain effects will result, and degree of improvement in psychotherapy. (p. 174)

Another correlation was obtained on the single scale item which provides the clearest and most direct statement the scale in total is designed to measure. Post item 12, a straight-forward expected therapeutic gain question, was compared to the post-scale score by means of

the product-moment correlation; the logic herein being that the content of the item which semantically correlates most highly with what the scale is asking can be viewed as a general measure of the content of the construct measured by the scale.

The correlation ($r=.61$) in this case is moderate. The r^2 is .372 and indicates the proportion of the variation in common with the total score; .628 may then be an indication of the unique contribution made by this item. This conclusion might be normal as a scale is composed of different and varied elements that do not correlate or, maybe, our semantics are defective and we are in fact measuring two or more different variables that should be given separate treatment.

The rather low correlations obtained above, while demonstrating a significant relationship, indicate that the measured expectancy is not a discrete phenomenon and that some independent information is provided by the scale score. This author agrees with Baggaley (1964) that

For the purposes of construct validity, finding out the variables that correlate low with a particular test is as important as learning the variables that correlate high with the test.
(p. 68)

Another consideration regarding this author's approach deals with scale assumptions. Wert et al. (1954) caution that analyzing items

... by correlating the responses to each item with the total test score assumes that the total score is an appropriate index of the behavior which the test has been designed to measure. Thus selecting items for a test which correlate high with their total score tends to yield items which correlate high with each other. It can then be seen, that it is only appropriate to use a total score as a criterion when the behavior measured by the total score is homogeneous.
(p. 339)

The present study treats the individual as a composite-cluster of mood-attitude and the anticipatory behavior measured by the scale may well not be homogeneous. The attempt is to inquire as to the nature of the individual holistically and a composite measure was used because people are composite, not discrete elements readily lending themselves to isolation and scientific analysis.

The real issue in question, then, is the construct validity of the final scale. Specifically, is there any reason to believe that the client's expectation of being helped is the factor that results in whatever consistency emerges in responses to scale items. Determining instrument reliability is not an easy task whenever attitude-behavior research is involved and this study is confounded even more so as measurement can't be based on independent, observed changes in behavior. Therapeutic gain is dealt with only as it can be ascribed to the first interview.

Further Analysis and Research Needed

Based upon the data presented it can reasonably be concluded that the scale as tested possesses face validity and a presumed slight to moderate degree of reliability regarding client expectation of treatment success and the counselor's perception of the client's expectancy state. Results obtained cannot be negated on the comparative basis of prior expectancy research as this is not an extensively investigated attitude and conclusions reached are contradictory (often, seemingly a function of the theoretical orientation held by the clinical researcher).

In order to refine the scale with the view of making it both operational and useful, two requirements, in this writer's opinion, need to be met—scale reliability and predictive validity.

Item analysis will help reach the major goals of improvement of total-score reliability or total-score validity, or both (Guilford, 1965). This is necessary in order to make sure that all scale items are functioning; that they are working as units of measurement and enabling differentiation between the better and poorer items. This approach is believed appropriate in the present design as such evaluation involves comparing the responses to an item when it is used in both pre- and post-tests. One of the most frequently used statistical procedures for item analysis is that of obtaining the correlation between item responses and total test score. This was very selectively attempted (as there are literally hundreds of such correlations possible) for suggestive purposes via the long-hand method in the present analysis.

Factor analysis can serve the interest of scale economy by indicating which items can be added and studied as a unitary whole rather than separately; thus serving to limit the tangle of variables with which the researcher must cope. Analysis of this type should help to locate and identify the fundamental expectancy properties underlying the instrument.

If the scale can be made reliable, prediction of outcome would be the next logical step in such a research program. At present we have no confidence in predicting any particular relationship between degree of expectancy and degree of improvement through counseling. Perhaps the most difficult aspect of the predictive-validity problem involves obtaining adequate criteria for what we are trying to measure. The factor-analysis approach is one solution when a primary trait such as expectancy is that we wish to measure. The author is currently engaged

in computer-testing the instrument by means of the cluster method whereby clusters and presumed factors are identified by searching for inter-related groups of correlation coefficients or other measures of relation.

Concluding Comments

This study represents a tentative examination of the general hypothesis that entering client expectation is related to subsequent first-interview counseling results. The author believes there is justification for generalizing from the single interview to the extent it serves as a singular reflection of the overall treatment series. It is well-accepted in terms of principle that of all the counseling sessions, the first is without peer in terms of importance as it bears upon the total counseling relationship.³ The more important question as it bears upon this study is whether the notion of expectancy is worth studying at all. Heine and Trosman (1960) argue that expectancy is a determinant as to whether therapy occurs or continues. Expectation may not lead directly to therapeutic gain, but instillation of expectancy may keep a person until more potent forces for change come into play. This author's opinion is that the expectation of improvement in life is very important because hope for a better future is perhaps the prime life-motivating force for many at some point in time.

NOTES

¹ Perhaps this consistently lower rating by the counselor could appropriately be termed a "pessimism index." A number of factors may help account for this variation between client and counselor perceptions: the counselor's experience and therapeutic "realism" and desire to keep his own expectations at a reasonable level; the client's "halo" reaction to the counselor; the disproportionate increase in expectancy once the client has taken the first counseling step; the possibility that a little gain may make the client feel a lot better; and, that the client is thinking subjectively and the counselor objectively. Chance (1960) found therapists to underestimate the amount of emotion displayed in early therapy hours. This observation bears upon the question to the extent that expectancy (anticipation, belief, hope, faith, etc.) is an emotion or has emotional overtones.

² The test-retest method was not considered appropriate in view of the possibility that expectancy level may change significantly during the period between testings and due to the uncertainty of follow-up access to subjects. The split half method was not considered appropriate due to the shortness of the scale.

³ For example see Lewin (1970, 48-79).

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APPENDIX A

EXPECTANCY QUESTIONNAIRE

NAME _____

DATE _____

The purpose of these questions is to help us to understand what people expect from the counseling they receive here. Please try to answer each of the questions frankly. There are no right or wrong answers. Please place the questionnaire in the attached envelop and seal it when completed. This is part of an independent research project and your counselor will not see your answers.

Please circle the letter of the alternative you choose for each question. Your help is sincerely appreciated!

(NOTE--The term "personal problems" in some of the items refers to any emotional or nervous difficulties you may be experiencing. Examples of these might be: getting very depressed, very angry, very tense, very upset.)

1. I am here for help with. . .
 - a. educational problems.
 - b. problems with my family.
 - c. personal or emotional problems.
 - d. other problems.
2. In personal matters in my daily life, I. . .
 - a. couldn't be better, everything is fine.
 - b. am getting along fairly well.
 - c. am not doing too well.
 - d. feel like I am barely getting by.
- * 3. How helpful do you believe your counseling here will be?
 - a. I am almost certain that counseling will be of help.
 - b. I am hopeful that counseling will be of help.
 - c. I am somewhat doubtful that counseling will be of help.
 - d. I do not really believe that this counseling will help me.
- * 4. How well do you expect to feel about your problem(s) a month from now as a result of the counseling you receive here?
 - a. Much worse than before I came here.
 - b. Somewhat worse than before I came here.
 - c. Somewhat better than before I came here.
 - d. Much better than before I came here.
5. Do you expect to need some kind of counseling again within six months?
 - a. I definitely will require some kind of counseling within six months.
 - b. I probably will require counseling within six months.
 - c. I probably will not require counseling within six months.
 - d. I definitely will not require counseling within six months.
6. The personal problem(s) I am now having. . .
 - a. will probably affect me in some ways for the rest of my life.
 - b. will probably affect me for a period of from six months to several years.
 - c. will probably affect me for a period of one to six months.
 - d. will probably affect me for just a few days or weeks.

- * 7. From what I know so far, I feel that the staff members here are. . .
- highly competent.
 - competent.
 - fairly competent.
 - not too competent.
- * 8. I intend to follow the suggestions of the counselors here. . .
- as closely as I can because whatever they say will be helpful.
 - pretty closely because most of their ideals will be helpful.
 - to some extent, but a low of their ideas probably won't be helpful.
 - very little because they don't know what will be helpful to me.
- * 9. I would encourage a friend who wanted the best help with a problem similar to mine to. . .
- immediately seek the type of help that is available here.
 - seriously consider this type of help.
 - seek other sources of help before coming to a place like this.
 - avoid this type of counseling if possible.
- * 10. From my experience or to the best of my knowledge, I think I could do. . .
- a much better job of helping people than the staff here.
 - at least as good a job of helping people as the staff here.
 - no better of a job of helping people than the staff here.
 - much less than the staff here is doing to help people.
11. How did you feel about your first appointment here?
- I dreaded coming.
 - I was somewhat ill at ease about coming.
 - I had no particular feeling, either good or bad, about coming.
 - I felt good about coming.
- * 12. I think my chances of doing better about my problem(s) because of this counseling are. . .
- extremely poor.
 - fairly poor.
 - fairly good.
 - extremely good.
- * 13. I feel that coming here for help with my problem(s). . .
- is one of the best things I have ever done.
 - is better than trying to work things out by myself.
 - is not going to be of much help.
 - is going to be a waste of time.
14. I expect that I will need to continue some kind of counseling here for. . .
- about six months to a year.
 - about one to six months.
 - a few weeks at most.
 - no longer than just today.

- * 15. If there is some part of my counseling I don't understand I will. . .
- a. go along, having faith that the staff knows what they're doing.
 - b. go along, but feel a little unsure.
 - c. be very hesitant to go along.
 - d. refuse to cooperate.
- * 16. I feel the staff here is probably. . .
- a. very concerned with my welfare.
 - b. moderately concerned with my welfare.
 - c. little concerned with my welfare.
 - d. unconcerned with my welfare.
17. I have been attending religious services. . .
- a. about every week.
 - b. about once a month.
 - c. only on special occasions such as holidays.
 - d. rarely or never.
- * 18. How willing were you to come here for counseling?
- a. I was very reluctant and came only because someone else insisted.
 - b. I was reluctant but decided to come just out of curiosity.
 - c. I wasn't sure about coming but felt I had nothing to lose.
 - d. I wanted to come and sought counseling.
- * 19. Just talking to someone about my problem(s) will. . .
- a. help me a great deal.
 - b. help me somewhat.
 - c. help me little.
 - d. help me not at all.
20. My friends and family. . .
- a. were against my coming here.
 - b. were indifferent about my coming here.
 - c. were glad about my coming here.
 - d. don't know I'm coming here.
21. I feel that the problem(s) that brought me here are. . .
- a. very serious.
 - b. pretty serious.
 - c. not too serious.
 - d. not very serious at all.
22. After talking with my counselor today I expect to feel. . .
- a. worse than I do now.
 - b. about the same as I do now.
 - d. somewhat better than I do now.
 - e. much better than I do now.

APPENDIX B

POST-QUESTIONNAIRE ITEM 22

22. Right at this moment I feel. . .

- a. worse than before I saw my counselor.
- b. about the same as I did before I saw my counselor.
- c. somewhat better than before I saw my counselor.
- d. much better than before I saw my counselor.